		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042614

Facility Name: Golfview Developmental Center

Address: 9555 Golf Road (Number) Des Plaines (City) 60616 (Zip Code)

County: Cook

Telephone Number: (847) 827-6628 **Fax #** (847) 827-0948

IDPA ID Number: 362935353001

Date of Initial License for Current Owners: 11/17/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael Kaplan **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	135	Intermediate/DD	135	49,410	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,410	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	47,984			47,984	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,984			47,984	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.11%

D. How many bed-hold days during this year were paid by Public Aid? 913 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 11/17/97

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 11/17/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified N/A and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	A. General Services											
1	Dietary	224,561	37,888	12,023	274,472		274,472		274,472			1
2	Food Purchase		257,706		257,706		257,706	(40,845)	216,861			2
3	Housekeeping	281,630	51,688		333,318		333,318		333,318			3
4	Laundry	45,882	11,270		57,152		57,152		57,152			4
5	Heat and Other Utilities			197,202	197,202		197,202		197,202			5
6	Maintenance	45,518	17,988	96,398	159,904		159,904	8,891	168,795			6
7	Other (specify):*											7
8	**TOTAL General Services**	597,591	376,540	305,623	1,279,754		1,279,754	(31,954)	1,247,800			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,787,034	30,691	167,581	1,985,306		1,985,306		1,985,306			10
10a	Therapy			43,134	43,134		43,134		43,134			10a
11	Activities	65,126	8,900		74,026		74,026		74,026			11
12	Social Services			19,350	19,350		19,350		19,350			12
13	Nurse Aide Training	78,258	1,600		79,858		79,858		79,858			13
14	Program Transportation							7,366	7,366			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,930,418	41,191	231,265	2,202,874		2,202,874	7,366	2,210,240			16
	C. General Administration											
17	Administrative	156,297		389,348	545,645		545,645	(389,348)	156,297			17
18	Directors Fees											18
19	Professional Services			341,357	341,357		341,357	(26,255)	315,102			19
20	Dues, Fees, Subscriptions & Promotions			102,806	102,806		102,806	(615)	102,191			20
21	Clerical & General Office Expenses	170,046	47,750	29,190	246,986		246,986	5,010	251,996			21
22	Employee Benefits & Payroll Taxes			404,462	404,462		404,462	40,845	445,307			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,307	2,307		2,307		2,307			24
25	Other Admin. Staff Transportation			9,821	9,821		9,821	(7,366)	2,455			25
26	Insurance-Prop.Liab.Malpractice			41,824	41,824		41,824	46,452	88,276			26
27	Other (specify):*											27
28	**TOTAL General Administration**	326,343	47,750	1,321,115	1,695,208		1,695,208	(331,277)	1,363,931			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,854,352	465,481	1,858,003	5,177,836		5,177,836	(355,865)	4,821,971			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Golfview Developmental Center #0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			11,964	11,964		11,964	305,865	317,829			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			133,592	133,592		133,592	611,833	745,425			32
33	Real Estate Taxes							253,084	253,084			33
34	Rent-Facility & Grounds			1,378,276	1,378,276		1,378,276	(1,378,276)				34
35	Rent-Equipment & Vehicles			38,855	38,855		38,855		38,855			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,562,687	1,562,687		1,562,687	(207,494)	1,355,193			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		914		914		914		914			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			342,470	342,470		342,470		342,470			42
43	Other (specify):* Nonallowable costs			16,591	16,591		16,591	(16,591)				43
44	**TOTAL Special Cost Centers**		914	359,061	359,975		359,975	(16,591)	343,384			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,854,352	466,395	3,779,751	7,100,498		7,100,498	(579,950)	6,520,548			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,981)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	829	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(466)	43		13
14	Non-Care Related Interest	(158,121)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(54)	43		18
19	Entertainment	(553)	43		19
20	Contributions	(409)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	1,579	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule 5A	(414,652)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (584,828)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	4,878		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 4,878		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (579,950)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

GOLFVIEW DEVELOPMENTAL CENTER
PROVIDER # 0042614
12/31/2000

Schedule 5A

VI. ADJUSTMENT DETAIL
NON-ALLOWABLE EXPENSES
LINE 29 - Other

Description	Amount	Reference
To Disallow Finance Charges	(3,707)	43
To Disallow Management Fees	(389,348)	17
To Disallow Professional Fees	(26,762)	19
To Disallow Deferred Maintenance	319	6
To Disallow PAC Dues	(615)	20
Related Party Interest Income	3,280	n/a
Related Party Miscellaneous Income	2,181	n/a
Total	(414,652)	

See Accountants' Compilation Report

STATE OF ILLINOIS

Golfview Developmental Center

ID# 0042614

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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26				26
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31				31
32				32
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76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bertram Miner	50.00%			Golfview Realty		
Lloyd Berhoff	50.00%			Partnership d/b/a	Chicago	Real Estate
				Golfview Partnership		
				Venture		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Repairs & Maintenance	$	Golfview Realty Partnership	100.00%	$ 8,572	$ 8,572	1
2	V	19	Professional Fees		Golfview Realty Partnership	100.00%	507	507	2
3	V	21	Bank Charges		Golfview Realty Partnership	100.00%	1,260	1,260	3
4	V	21	Communications		Golfview Realty Partnership	100.00%	3,750	3,750	4
5	V	26	Insurance		Golfview Realty Partnership	100.00%	46,452	46,452	5
6	V	30	Depreciation		Golfview Realty Partnership	100.00%	305,036	305,036	6
7	V	32	Interest Expense		Golfview Realty Partnership	100.00%	769,954	769,954	7
8	V	33	Real Estate Taxes		Golfview Realty Partnership	100.00%	253,084	253,084	8
9	V	34	Rent Expense	1,378,276	Golfview Realty Partnership	100.00%		(1,378,276)	9
10	V	32	Interest Income	3,280	Golfview Realty Partnership	100.00%		(3,280)	10
11	V	n/a	Miscellaneous Income	2,181	Golfview Realty Partnership	100.00%		(2,181)	11
12	V								12
13	V								13
14	Total			$ 1,383,737			$ 1,388,615	$ * 4,878	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Anthony Miner*	President	Administrator	None	None	50-60	100.00%	Salary	$ 98,144	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9	* Son of Bertram Miner										9
10											10
11											11
12											12
13								TOTAL	$ 98,144		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8					N/A					8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Capstone Realty Advisors, LLC		x	Mortgage	$63,106.00	2/9/96	$ 9,225,000	$ 9,109,905	11/01/37	0.0785	$ 716,484	1
2												2
3								Amortization of Loan Fees			11,964	3
4								Interest Income Offset			(33,638)	4
5								Miscellaneous			3,868	5
	Working Capital											
6	Parkway Bank		x	Working Capital	Interest only	1/1/00	500,000	500,000	12/31/00	Prime	46,747	6
7												7
8												8
9	TOTAL Facility Related				$63,106.00		$ 9,725,000	$ 9,609,905			$ 745,425	9
	B. Non-Facility Related*											
10	Shareholder Loans	x		Working Capital	Interest only	Various	1,100,000	804,587	Demand	P+.0100	82,978	10
11												11
12												12
13								Related Party Interest			(82,978)	13
14	TOTAL Non-Facility Related						$ 1,100,000	$ 804,587			$	14
15	TOTALS (line 9+line14)						$ 10,825,000	$ 10,414,492			$ 745,425	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 277,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 266,574	2
3. Under or (over) accrual (line 2 minus line 1).		$ (10,426)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 281,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ 17,490 For 19 94&98 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$ (17,490)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 253,084	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	77,324	8
1996	77,830	9
1997	75,130	10
1998	279,787	11
1999	266,574	12

1999 Adjusted Tax Assessment	266,574
5% Increase	105.00%
2000 Estimated Taxes	279,903
Use	281,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,011 B. General Construction Type: Exterior Brick Frame Steel Number of Stories Three

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	117,000	1977	$ 234,000	1
2					2
3	TOTALS	117,000		$ 234,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	128		1997	1997	$ 8,641,370	$	40	$ 216,034	$ 216,034	$ 666,106	4
5			1997		(580,616)		39	(14,888)	(14,888)	(37,988)	5
6			1998		40,292		40	1,007	1,007	2,519	6
7	7		1999	1999	52,495		40	1,312	1,312	1,968	7
8											8
	Improvement Type**										
9	Fencing			1997	1,200	120	10	120		420	9
10	Lobby Notice Board			1998	3,380	338	10	338		845	10
11	Parking Lot			1998	139,900		15	9,327	9,327	23,317	11
12	Exhaust System			1999	2,801		10	280	280	420	12
13	Compressor			1999	11,972		10	1,197	1,197	1,796	13
14	Fencing			1999	1,800		10	180	180	270	14
15	Fire Vents			1999	1,806		10	181	181	271	15
16	Elevator			1999	932		10	93	93	140	16
17	Security System			1999	970		10	97	97	146	17
18	Heat Unit			2000	715		10	36	36	36	18
19	Security System			2000	2,017		10	101	101	101	19
20	Telephone Line			2000	7,234		10	362	362	362	20
21	Security System			2000	2,087	104	10	104		104	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 8,330,355	$ 562		$ 215,881	$ 215,319	$ 660,833	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 851,452	$ 11,136	$ 100,901	$ 89,765	5-10 years	$ 329,147	37
38	Current Year Purchases	10,464	266	1,047	781	5-10 years	1,047	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 861,916	$ 11,402	$ 101,948	$ 90,546		$ 330,194	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 9,426,271	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 11,964	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 317,829	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 305,865	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 991,027	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 15,658 Description: Ice Machine $3,820; Copier $11,061; Postage $777
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Transportation	2000 Chevrolet Van	$ 549.00	$ 6,590	17
18	Resident Transportation	2000 Chevrolet Van	474.00	5,692	18
19	Administrative	2000 Mercedes	700.00	8,416	19
20	Resident Transportation	Misc. Car Rental		2,499	20
21	TOTAL		$ 1,723.00	$ 23,197	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	50

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		900	700		1,600
3	Classroom Wages	(a)	8,702	6,301		15,003
4	Clinical Wages	(b)	9,302	15,176		24,478
5	In-House Trainer Wages	(c)	22,387	16,390		38,777
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 41,291	$ 38,567	$	$ 79,858
10	SUM OF line 9, col. 1 and 2	(e)	$ 79,858			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	28
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	38
2. From other facilities (f)	
TOTAL TRAINED	66

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	L39, C2	visits				869		869	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory Therapy	L39, C2					45		45	13
14	TOTAL			$		$	$ 914		$ 914	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center **#** 0042614 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,682	$ 6,088	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 0)	1,066,046	1,066,046	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,555	89,509	6
7	Other Prepaid Expenses	14,695	14,695	7
8	Accounts Receivable (owners or related parties)	670,111		8
9	Other(specify): See Attached Schedule 17B	2,500	410,805	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,804,589	$ 1,587,143	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		234,000	13
14	Buildings, at Historical Cost		8,142,737	14
15	Leasehold Improvements, at Historical Cost	7,929	187,618	15
16	Equipment, at Historical Cost	71,547	861,916	16
17	Accumulated Depreciation (book methods)	(35,956)	(991,027)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule 17B	515,485	1,092,706	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 559,005	$ 9,527,950	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,363,594	$ 11,115,093	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,045,682	$ 1,099,696	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,404,587	1,304,587	29
30	Accrued Salaries Payable	234,740	234,740	30
31	Accrued Taxes Payable (excluding real estate taxes)	564	564	31
32	Accrued Real Estate Taxes(Sch.IX-B)		281,000	32
33	Accrued Interest Payable		59,594	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17B	1,906,357	1,084,298	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,591,930	$ 4,064,479	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		9,109,905	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,109,905	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,591,930	$ 13,174,384	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,228,336)	$ (2,059,291)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,363,594	$ 11,115,093	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,493,097)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,493,097)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(735,239)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (735,239)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,228,336)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,143,920	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,143,920	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	42,549	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 42,549	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	71,863	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 71,863	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bedhold Early Discharge	106,927	28
28a	Miscellaneous Income		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 106,927	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,365,259	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,279,754	31
32	Health Care	2,202,874	32
33	General Administration	1,695,208	33
	B. Capital Expense		
34	Ownership	1,562,687	34
	C. Ancillary Expense		
35	Special Cost Centers	17,505	35
36	Provider Participation Fee	342,470	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,100,498	40
41	**Income before Income Taxes (line 30 minus line 40)****	(735,239)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (735,239)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,735	2,049	$ 48,727	$ 23.78	1
2	Assistant Director of Nursing	1,765	2,080	49,817	23.95	2
3	Registered Nurses	11,311	12,258	216,089	17.63	3
4	Licensed Practical Nurses	3,525	3,645	63,783	17.50	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	4,929	4,929	39,481	8.01	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,834	1,984	23,372	11.78	8
9	Activity Director					9
10	Activity Assistants	5,242	5,604	65,126	11.62	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,335	22,831	224,561	9.84	15
16	Dishwashers					16
17	Maintenance Workers	2,781	3,001	45,518	15.17	17
18	Housekeepers	29,166	31,280	281,630	9.00	18
19	Laundry	3,409	3,952	45,882	11.61	19
20	Administrator	1,776	2,080	98,144	47.18	20
21	Assistant Administrator	1,748	2,080	58,153	27.96	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,381	11,968	170,046	14.21	24
25	Vocational Instruction					25
26	Academic Instruction	1,773	2,080	38,777	18.64	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	14,528	16,166	234,778	14.52	28
29	Resident Services Coordinator	1,629	1,812	31,158	17.20	29
30	Habilitation Aides (DD Homes)	98,046	105,117	1,119,310	10.65	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	216,913	234,916	$ 2,854,352 *	$ 12.15	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	319	$ 12,023	L1,C3	35
36	Medical Director	48	1,200	L9,C3	36
37	Medical Records Consultant	52	3,640	L10,C3	37
38	Nurse Consultant	97	1,972	L10,C3	38
39	Pharmacist Consultant	48	5,100	L10,C3	39
40	Physical Therapy Consultant	123	6,903	L10a,C3	40
41	Occupational Therapy Consultant	419	21,801	L10a,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	278	14,430	L10a,C3	43
44	Activity Consultant				44
45	Social Service Consultant	430	19,350	L12,C3	45
46	Other(specify)				46
47	Psychiatrist	72	9,000	L10,C3	47
48	Psychologist	319	23,888	L10,C3	48
49	TOTAL (lines 35 - 48)	2,205	$ 119,307		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,563	$ 107,961	L10,C3	50
51	Licensed Practical Nurses	446	16,020	L10,C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	3,009	$ 123,981		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anthony Miner	Administrator	0.00%	$ 98,144
Kathy LoBue	Asst. Administrator	0.00%	58,153
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 156,297

B. Administrative - Other

Description	Amount
Management Fees - eliminated in column 7	$ 389,348
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 389,348

C. Professional Services

Vendor/Payee	Type	Amount
HDSI	Computer services	$ 17,496
American Arbitration Association	Legal	21,548
Ronan - Potts	Legal	10,000
Carmell, Charone, Widmer	Legal	54,249
Torshen, Spreyer, & Garmisa	Legal	183,579
Altheimer & Gray	Legal	225
Rosenthal & Schanfield	Legal	5,290
Personnel Planners	U/C consultants	2,201
American Express TBS	Accounting	41,188
RSM McGladrey Inc.	Accounting	3,000
Shayman, Salk, Aren, Sussholtz	Architecture consultants	1,968
Miscellaneous professional fees	Various	613
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 341,357

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,804
Unemployment Compensation Insurance	15,564
FICA Taxes	215,091
Employee Health Insurance	70,302
Employee Meals	40,845
Illinois Municipal Retirement Fund (IMRF)*	
Union Health & Welfare	45,530
Other Employee Benefit	13,498
Employee Pensions	21,415
Employee Vaccinations	976
Gifts	282
TOTAL (agree to Schedule V, line 22, col.8)	$ 445,307

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,400
Advertising: Employee Recruitment	86,343
Health Care Worker Background Check (Indicate # of checks performed 83)	1,162
Illinois Health Care Association	5,617
Magazine and Newspaper Subscriptions	2,086
Cook County Collector	769
Secretary of State	700
Miscellaneous Licenses & Fees	804
Less: Public Relations Expense	( )
Non-allowable Sam's Club	(75)
Non-allowable PAC dues	(615)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 102,191

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,307
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,307

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting and Decorating	Dec - 97	$ 1,917	3	$ 320	$ 639	$ 639	$ 319	$	$	$	$	$
2													
3													
4													
5													
6													
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16													
17													
18													
19													
20	TOTALS		$ 1,917		$ 320	$ 639	$ 639	$ 319	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Golfview Developmental Center # 0042614 Report Period Beginning: 1/1/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illnois Health Care Association $5,617**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **342,470**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **40,845** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **75%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.